Washington State Health Home Model

Hypothetical Chronic Care Management Mental Health Patient Scenario

Patient Background: "Bobby": Bobby is a 45 year old single male with a current primary mental health diagnosis of schizophrenia. Since his initial diagnosis at age 22, Bobby has been prescribed a wide range of traditional and atypical antipsychotics and mood stabilizers which frequently require re-adjustment to manage his symptoms. Even when fully medication adherent, Bobby still experiences symptoms—he is still tormented by voices, fearful of strangers and experiences sleep disturbances. Bobby's treatment history includes four involuntary hospitalizations.

Bobby currently lives alone. He no longer has contact with his parents or siblings because they do not understand why he just does not stay on his medications or take enough medications to be "normal." He has been evicted multiple times due to being disruptive to neighbors (because he stands in corner at night and screams due to the voices) and for doing property damage. Based on delusions regarding fiberglass insulation and wiring, Bobby usually removes both from the interior walls of his residence. He also has fear of being naked and accordingly seldom bathes or showers.

Bobby receives intermittent case management services from a local community mental health agency (CMHA). Bobby is difficult to engage, occasionally disappears for weeks at a time and frequently misses his prescriber and medication monitoring appointments.

Bobby does not have a primary care physician. He is fearful of community medical clinics and does not willingly go to them. Community clinics complain about him when he is in the waiting room due to body odor, mumbling to himself and scaring other patients. Due to heavy tobacco use and untreated bronchitis, Bobby has developed COPD. Bobby has had multiple ER visits due to symptoms of his mental illness and COPD. Typically he is brought to the ER by law enforcement, his case manager or a crisis worker.

Initiating Health Home Services: There are two pathways for initiating Bobby's Washington's Health Home services:

1. Based on Bobby's mental health diagnosis, COPD, and ER utilization, he received a predictive modeling score of 1.5 or higher and was auto-enrolled with one of the qualified health home networks in the geographic region in which he resides. He received outreach and education information sent by mail from the state. The health home network assigned him to his CMHA as it was contracted as a health home care coordination organization. The CMHA then organized outreach engagement activities to work with Bobby to educate him on health home services and help him determine if he would like to receive them. (Note: Unless the client is present, coordination with primary care is not a covered service prior to health homes.)
2. Shortly following Bobby's last ER visit, he was added to a list of persons to be actively sought for engagement by a health home network because he had more than two avoidable emergency room visits in the last 15 months. This referral came through the local emergency department who has agreed to refer eligible participants to the program. The referral to the health home network was then pushed out to the contracted health home care coordination organization. In this case, the care coordination organization is already familiar with this client, however that may not always be the case.

Fortunately for Bobby, the CMHA which he has been working with has recently become a Care Coordination organization within the health home network. Bobby was assigned to Melody, an RN health home care coordinator. The RN care coordinator takes the following steps:

- ✓ Uses the Predictive Risk Intelligence SysteM (PRISM) to review Bobby's PRISM claims utilization - 15 month history of care provided by Medicaid and/or Medicare. PRISM information includes episode information related to specific diagnoses or pharmacy utilization; inpatient and outpatient claims, emergency room visits and care, mental health claims, alcohol and other drug treatment claims, pharmacy claims and long-term care assessment data.
- ✓ Collaborates with and augments Billy's existing treatment team within the CMHA to coordinate mental health and primary care and identifying who on team should lead for engagement
- ✓ Develop engagement strategies to involve Bobby in developing the plan and actively participate in his own mental health and primary care treatment.

The PRISM Health Report indicates that Bobby has not been regularly filling prescriptions for his antipsychotics and mood stabilizers, even though he has been telling his prescriber and case manager that he has been regularly taking his medications. The report confirms that Bobby has not been seeing a primary care physician. The report also indicates that Bobby has been presenting at the emergency rooms at multiple hospitals far more than his case manager had realized.

Client Engagement and Enrollment: Given Bobby's pattern of sporadic engagement with treatment services, the Care Coordinator and his treatment team decide to use a Peer Specialist to initiate engagement with health home services. The Peer Specialist accompanied with his case manager attempt multiple home visits to meet with Bobby. After the third attempted visit they find Bobby at home and he lets them into his apartment. The case manager introduces Bobby to the Peer Specialist who notices Bobby has an old Xbox and a couple gaming magazines on the floor. The Peer engages with Bobby on gaming and computers. Bobby agrees to have the Peer visit him again to talk and play a computer game. At the next visit the Peer explains to Bobby what it means to participate in the health home and what it would do for him—helping with health his cough, making it easier to go to clinics, figuring out how Bobby can sleep all night without frequently waking up. Bobby agrees to participate in Washington's Health Home Services and meet with Melody, the RN Health Home care coordinator. The Peer sets up an appointment for Bobby with Melody and offers to sit in with Bobby during the meeting. At the meeting Melody :

1. Provides an introduction of the program including a description of care coordination and the Health Home Services.
2. Completes a brief health screening including physical and chemical dependency questionnaires.
3. Evaluates Bobby's support system.
4. Completes a ***Consent for Release of Information*** primary care providers.
5. Administers and scores the 13-question ***Patient Activation (PAM)*** or ***Caregiver Activation Measure (CAM).***
    a. The PAM measures activation and behaviors that underlie activation including ability to self-manage, to collaborate with providers, to maintain function, prevent declines and to access appropriate and high quality health care.
    b. The PAM helps health home care coordinators to target tools and resources commensurate with the beneficiary's level of activation

c. The PAM provides insight into how to improve unhealthy behaviors and grow and sustain healthy behaviors to lower medical costs and improve health.

6. Offers to set Bobby up with an appointment with a primary care clinic.

The health home care coordinator notes the following healthcare problems by a combined review of PRISM and the initial home visit with Bobby:

- ✓ Bobby does not have an ongoing relationship with a primary care physician.
- ✓ Bobby uses the Community Hospital emergency room for his medical care.
- ✓ Bobby's health literacy level is low; he does not have any understanding of his COPD diagnoses, of his prescribed medications nor the importance of routine medical care. Bobby admits to never reading discharge instructions from his recent emergency room visits. He is scored at a low level of activation using the PAM.
- ✓ Bobby was diagnosed with COPD over four years ago, but has not accessed any type of patient education. Bobby has no understanding of what the diagnosis means.
- ✓ Bobby intermittently adheres with his psychiatric medications. He does not readily grasp the connection between regularly taking his medications and his ability to function on a day-to-day basis.
- ✓ Bobby has no informal support system and isolates himself.

Health Action Plan Development: During the initial visit with Melody, she asks Bobby if she can visit him in his home. Bobby agrees, as long as his Peer Specialist is there as well. At the first home visit, Melody introduces the ***Health Action Plan (HAP)*** to Bobby; she explains that *the Health Action Plan* is a tool to help guide Bobby towards appropriate choices, attainable goals, action steps and improved health. Together, Bobby, Melody and the Peer Specialist identify things that have been tried in the past, what has worked and what has not worked in regards to Bobby's primary and mental health care. Together, the care coordinator, the Peer and Bobby identify immediate and long-term goals, prioritize concerns and establish immediate action steps. Bobby's initial HAP included finding and establishing care with a primary care provider.

Next, the Peer, the health home care coordinator and Bobby complete a ***Goal & Action Planning Worksheet*** to describe what steps Bobby would like to take first, to identify possible barriers, his plans to overcome barriers, and to measure how important and how confident Bobby feels about this first goal.

Bobby's immediate goal is to obtain a primary care provider. Bobby rates this goal as an "9" on a 1-10 scale of importance; however, he rates his confidence in attaining the goal as a "1" on a 1-10 scale of confidence. Bobby admits that this goal makes him very anxious. Melody suggests that the Peer and Bobby work together to develop steps that Bobby can take, with support from the Peer, and what steps the health home care coordinator will take to help with this goal and to increase his level of confidence.

Care Coordination: The health home care coordinator tells Bobby that she will give Bobby and his Peer Specialist a list of three clinics relatively near his apartment that are accepting new patients. Bobby and his Peer tell Melody that Bobby's biggest concern is not *finding* a clinic, but actually *going* to the clinic. Bobby tells Melody that she is asking for too much change at once. Melody writes out a plan that Bobby can comfortably agree to:

1. The Peer will drive Bobby by each of the three clinics. Bobby will choose the building he likes best.

2. Melody will contact that clinic and tell them Bobby will be visiting the waiting room of that clinic over the next few weeks.
3. Two times a week Bobby and the Peer will sit in the waiting room of the clinic for an incrementally increasing length of time. The first time will be ten minutes.
4. Bobby will wash up prior to going to the clinic with the Peer.
5. On the third week, Bobby's new doctor will come to the waiting room and introduce himself, but Bobby will not have to go to an exam room.
6. During the fourth week Bobby will wait in the waiting room with the Peer and then go to an exam for a short period of time. The doctor will come by and say hello.
7. During the fifth week, the doctor will do a brief exam.

Bobby likes the plan and thinks it might work and states he is willing to try as long as the Peer sits with him at the clinic.

They agree that Melody will check-in with the Peer a couple times a week to see how the plan is working. Bobby agrees to allow Melody to phone him once a week to talk about his progress. They set times for the weekly phone calls to make sure Bobby will be at home. The Peer promises to remind Bobby about the phone calls.

After Bobby chooses the clinic, the health home care coordinator completed a new Consent to Release of Information for the Peer to take to Bobby for signature. Upon receipt of the release form, the health home coordinator then visited the new provider, met with the doctor and his nurse, provided a letter of introduction and the PRISM health report and in a subsequent visit with the nurse, secured the clinic's participation in Bobby's desensitization plan.

Other than a panic attack during the first visit to the waiting room, the plan works. After five weeks Bobby is able to meet with his new doctor and be examined. The doctor prescribed medication for his COPD and in conjunction with Melody, a plan of treatment was developed and explained to Bobby. The Peer and Melody and Bobby had a celebration in honor of Bobby's making it through his first medical appointment. The health home care coordinator congratulated client on taking action regarding his health and promoted the benefits of developing a good relationship with a primary care physician. [Since the new provider is part of the same health network as the coordinated care organization, Melody secured an agreement with the clinic to allow the Peer Specialist and Melody to do initial medication deliveries and medication cuing for any newly prescribed medications.]

Maintenance of Health Action Plan: The health home care coordinator continues to work with Bobby to promote self-efficacy, review his strengths and successes and to help him achieve his health related goals. With the Peer, Bobby and Melody set up a series of goals with rewards. The goals include both COPD medication adherence, but also psychiatric medication adherence. Most of the rewards involve playing video games.

At the end of the fourth month Bobby has identified as his new immediate goal to have an assessment with a dietitian for recommendations for a more healthy diet. The health home coordinator uses coaching techniques to help Bobby identify his action steps for this goal.